

# Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

## I. Request Information

- A. The State of **Maryland** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. Waiver Title (optional): **Family Supports Waiver**
- C. CMS Waiver Number: **MD.1466**
- D. Amendment Number (Assigned by CMS):
- E.1 Proposed Effective Date: **7/1/2019**
- E.2 Approved Effective Date (CMS Use):

## II. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:

The purpose of this amendment is to continue to: (1) support DDA's five priority focus areas (employment, self-determination, self-direction, supporting families, and supported housing); (2) align the waivers with DDA's transformation and incorporate feedback received through DDA transformation meetings, trainings, and presentations; (3) support program integrity (e.g. quality assurance/federal performance measures, protect people's rights, prevent fraud); and (4) ensure fiscal accountability.

The first amendment will include programmatic adjustments, such as:

1. Alignment of the services scope, requirements, limitations, qualifications, and effective date for the three home and community-based service waivers programs that support individuals with developmental disabilities which includes the Family Supports Waiver, Community Supports Waiver, and the Community Pathways Waiver.
2. Adjustment of some of the service implementation to provide additional time for rate setting and development of critical operational and billing functionality.

Notable changes in each Appendix in this amendment include:

Alignment of language and terminology throughout the appendices with the comprehensive waiver.

Appendix A

1. Request to change waiver year start from January to July to align with the comprehensive waiver.
2. Development of a transition plan.

Appendix B

1. Exclusion of one time cost, such as assistive technology, environmental modifications, vehicle modifications, and staff recruitment and advertisement, from the budget limit (i.e. funding cap).
- ~~1.2.~~ Authorization of additional supports and funding above the cap to meet increased needs based on demonstrated assessed need.
3. Adjustments to the projected number of individuals served (i.e. slots) based on current experience.

Appendix C

1. Alignment of all services scope, requirements, limitations, qualifications, and effective date for the DDA home and community-based waivers;
2. Adjustment of some service effective dates from July 2019 to July 2020 to provide additional time for rate setting and development of critical operational and billing functionality;
3. Changes in behavioral support services qualification requirement including clinician experience and competencies and support staff behavioral technician training;
4. Addition of nurse consultation and nurse case management and delegation services as a waiver services;
5. Improvements to respite that include (1) a daily rate will be used for licensed sites and hourly rate for in/out of home services; (2) increase service to include a daily/hourly limit up to 360720 hours/year plus up to \$7,248 toward camps; and (3) adjustment to staff qualifications (i.e. GED/HS Diplomas/Age requirements);
6. Change of terminology related to DDA-approved providers to DDA-certified providers; and
7. Updates to criminal background checks including new draft requirements.

Appendix E

1. Addition of budget authority for nurse consultation and nurse case management and delegation services.

Appendix I and J

1. Addition of nurse consultation and nurse case management and delegation services.
2. Adjustments to estimated users and projections.
- ~~1.3.~~ Adjustment to behavioral support consultation services from an hourly unit to a fifteen minute unit.
4. Payment systems will transition to Maryland's Long Term Services and Supports (LTSSMarylandMDLTSS) system on July 1, 2020.

### III. Nature of the Amendment

- A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

| Component of the Approved Waiver    |   | Subsection(s)                             |
|-------------------------------------|---|---|
| <input type="checkbox"/>            | Waiver Application  |   |
| <input checked="" type="checkbox"/> | Appendix A – Waiver Administration and Operation                | <u>A 6. I and Attachment #1</u>           |
| <input checked="" type="checkbox"/> | Appendix B – Participant Access and Eligibility                 | <u>B-1b.; B-2; B-3; B-4; B-5; and B-6</u> |
| <input checked="" type="checkbox"/> | Appendix C – Participant Services                               | <u>C-1/C-3; C-2</u>                       |
| <input checked="" type="checkbox"/> | Appendix D – Participant Centered Service Planning and Delivery | <u>D-1 and D-2</u>                        |
| <input checked="" type="checkbox"/> | Appendix E – Participant Direction of Services                  | <u>E-1 and E-2</u>                        |
| <input type="checkbox"/>            | Appendix F – Participant Rights                                 |   |
| <input checked="" type="checkbox"/> | Appendix G – Participant Safeguards                             | <u>G-1 and G-2</u>                        |
| <input checked="" type="checkbox"/> | Appendix I – Financial Accountability                           | <u>I-2</u>                                |
| <input checked="" type="checkbox"/> | Appendix J – Cost-Neutrality Demonstration                      | <u>J-1 and J-2</u>                        |

- B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

|                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/>            | Modify target group(s)                   |
| <input type="checkbox"/>            | Modify Medicaid eligibility              |
| <input checked="" type="checkbox"/> | Add/delete services                      |
| <input checked="" type="checkbox"/> | Revise service specifications            |
| <input checked="" type="checkbox"/> | Revise provider qualifications           |
| <input checked="" type="checkbox"/> | Increase/decrease number of participants |
| <input checked="" type="checkbox"/> | Revise cost neutrality demonstration     |
| <input type="checkbox"/>            | Add participant-direction of services    |
| <input type="checkbox"/>            | Other (specify):                         |
|                                     |  |

### IV. Contact Person(s)

- A. The Medicaid agency representative with whom CMS should communicate regarding this amendment is:

|                    |  |
|--------------------|--|
| <b>First Name:</b> | Marlana R.   |
| <b>Last Name</b>   | Hutchinson   |
| <b>Title:</b>      | Deputy Director, Nursing and Waiver Services   |
| <b>Agency:</b>     | Maryland Department of Health – Office of <u>Long Term Services and Supports Health Services (OLTSS)</u> |
| <b>Address 1:</b>  | 201 West Preston Street, 1 <sup>st</sup> Floor   |
| <b>Address 2:</b>  |  |
| <b>City</b>        | Baltimore  |
| <b>State</b>       | Maryland   |
| <b>Zip Code</b>    | 21201  |
| <b>Telephone:</b>  | (410) 767-4003   |
| <b>E-mail</b>      | marlana.hutchinson@maryland.gov  |
| <b>Fax Number</b>  | (410) 333-6547   |

- B.** If applicable, the operating agency representative with whom CMS should communicate regarding this amendment is:

|                    |   |
|--------------------|---|
| <b>First Name:</b> | Rhonda  |
| <b>Last Name</b>   | Workman   |
| <b>Title:</b>      | Director of Federal Programs  |
| <b>Agency:</b>     | Maryland Department of Health – Developmental Disabilities Administration |
| <b>Address 1:</b>  | 201 West Preston Street, 4 <sup>th</sup> Floor                            |
| <b>Address 2:</b>  |   |
| <b>City</b>        | Baltimore   |
| <b>State</b>       | Maryland  |
| <b>Zip Code</b>    | 21201   |
| <b>Telephone:</b>  | (410) 767-8690  |
| <b>E-mail</b>      | Rhonda.Workman@maryland.gov   |
| <b>Fax Number</b>  | (410) 333-5850  |

## V. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

**Signature:**

\_\_\_\_\_  
State Medicaid Director or Designee

**Date:**

|  |
|--|
|  |
|--|

|                    |                               |
|--------------------|-------------------------------|
| <b>First Name:</b> | Robert R.                     |
| <b>Last Name</b>   | Neall                         |
| <b>Title:</b>      | Secretary                     |
| <b>Agency:</b>     | Maryland Department of Health |
| <b>Address 1:</b>  | 201 W. Preston Street         |
| <b>Address 2:</b>  | 5 <sup>th</sup> Floor         |
| <b>City</b>        | Baltimore                     |
| <b>State</b>       | Maryland                      |
| <b>Zip Code</b>    | 21201                         |
| <b>Telephone:</b>  | 410-767-4639                  |
| <b>E-mail</b>      | Robert.neall@maryland.gov     |
| <b>Fax Number</b>  | 410-767-6489                  |

### 1. Request Information

A. The State of **Maryland** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (optional – this title will be used to locate this waiver in the finder): **Family Supports Waiver**

C. **Type of Request:** (the system will automatically populate new, amendment, or renewal)

**Requested Approval Period:** (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

|                                     |         |
|-------------------------------------|---------|
| <input type="checkbox"/>            | 3 years |
| <input checked="" type="checkbox"/> | 5 years |

|                          |   |                      |                      |
|--------------------------|---|----------------------|----------------------|
| <input type="checkbox"/> | <b>New to replace waiver</b><br>Replacing Waiver Number: <input type="text"/>   |                      |                      |
| <input type="checkbox"/> | <b>Migration Waiver</b> – this is an existing approved waiver<br>Provide the information about the original waiver being migrated |                      |                      |
|                          | <b>Base Waiver Number:</b>  | <input type="text"/> | <input type="text"/> |
|                          | <b>Amendment Number</b> (if applicable):  | <input type="text"/> | <input type="text"/> |
|                          | <b>Effective Date:</b> (mm/dd/yy)   | <input type="text"/> | <input type="text"/> |

D. **Type of Waiver** (select only one):

|                                  |                       |
|----------------------------------|-----------------------|
| <input type="radio"/>            | <b>Model Waiver</b>   |
| <input checked="" type="radio"/> | <b>Regular Waiver</b> |

E. **Proposed Effective Date:** **January 1, 2018**

**Approved Effective Date (CMS Use):**

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

|                          |   |
|--------------------------|---|
| <input type="checkbox"/> | <b>Hospital</b> (select applicable level of care) |
| <input type="radio"/>    | <b>Hospital as defined in 42 CFR §440.10</b>      |

|                                     |   |   |
|-------------------------------------|---|---|
|                                     |   | If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:   |
|                                     |   |   |
| <input type="radio"/>               |   | <b>Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160</b>  |
| <input type="checkbox"/>            | <b>Nursing Facility</b> ( <i>select applicable level of care</i> )  |   |
| <input type="radio"/>               |   | <b>Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155</b><br>If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care: |
|                                     |   |   |
| <input type="radio"/>               |   | <b>Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140</b>  |
| <input checked="" type="checkbox"/> | <b>Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)</b><br>If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID facility level of care: |   |
|                                     |   |   |

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

|                                  |  |   |
|----------------------------------|--|---|
| <input checked="" type="radio"/> | <b>Not applicable</b>  |   |
| <input type="radio"/>            | <b>Applicable</b>  |   |
|                                  | Check the applicable authority or authorities:   |   |
| <input type="checkbox"/>         | <b>Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I</b>  |   |
| <input type="checkbox"/>         | <b>Waiver(s) authorized under §1915(b) of the Act.</b><br><i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i> |   |
|                                  |  |   |
|                                  | Specify the §1915(b) authorities under which this program operates ( <i>check each that applies</i> ):   |   |
| <input type="checkbox"/>         | §1915(b)(1) (mandated enrollment to managed care)  | <input type="checkbox"/> §1915(b)(3) (employ cost savings to furnish additional services) |
| <input type="checkbox"/>         | §1915(b)(2) (central broker)   | <input type="checkbox"/> §1915(b)(4) (selective contracting/limit number of providers)    |
|                                  |  |   |
| <input type="checkbox"/>         | <b>A program operated under §1932(a) of the Act.</b>   |   |

|                          |  |
|--------------------------|--|
|                          | <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</i> |
|                          |  |
| <input type="checkbox"/> | A program authorized under §1915(i) of the Act.  |
| <input type="checkbox"/> | A program authorized under §1915(j) of the Act.  |
| <input type="checkbox"/> | A program authorized under §1115 of the Act.<br>Specify the program:   |
|                          |  |

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

|                                     |   |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | <b>This waiver provides services for individuals who are eligible for both Medicare and Medicaid.</b> |
|-------------------------------------|---|

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.*

The Family Supports Waiver is designed to provide support services to participants and their families, to enable participants' to work toward self-determination, ~~independence~~ independence, productivity, integration, and inclusion in all facets of community life across their lifespans. It supports individuals and families as they focus on life experiences that point the trajectory toward a good quality of life across the lifespan. Services can support integrated life domains that are important to a good quality of life, including daily life, safety and security, community living, healthy lifestyle, social and spirituality, and citizenship and advocacy. These services will build on each participant's current support structures to work toward individually defined life outcomes, which focus on developing the participant's abilities for self-determination, community living, socialization, and economic self-sufficiency.

The goals for the Family Supports Waiver include providing:

- Innovative service options aimed at providing supports that build on the DDA's existing ~~Supporting Families~~ Community of Practice, ~~particularly strengthening families' abilities to support their member with a disability related to Supporting Families~~;
- Participant and family self-direction opportunities;
- Flexibility for participants and families to move dollar amounts among line items within their approved Person-Centered Plan to meet the emerging and changing needs of the participant and family; and
- Short-term exceptions to the overall budget caps based on exceptional needs, such as family caregiver support needs, post hospitalization, and short-term care needs.



Waiver Organizational Structure:

The Maryland Department of Health (MDH) is the single state agency for Medicaid. MDH's Office of Health Services (OHS) Office of Long Term Services and Supports (OLTSS) is responsible for ensuring compliance with federal and state laws and regulations to the operation of the waiver. MDH's Developmental Disabilities Administration (DDA) is the operating state agency and funds community-based services and supports for people with developmental disabilities. The DDA has a Headquarters (HQ) and four Regional Offices (RO): Central, Eastern, Southern, and Western.

The DDA utilizes various agents, licensed providers, and contractors to support the administrative, operations, and direct service delivery. Medicaid State Plan targeted case management (TCM) services are provided by licensed Coordination of Community Services (CCS) agencies. The MDH's Office of Health Care Quality (OHCQ) performs licensing, surveys, and incident investigations.

Participants will receive case management services, provided by licensed Coordination of Community Services (CCS) providers, through the Medicaid State Plan Targeted Case Management (TCM) authority. Each CCS assists participants in developing a person-centered plan, which supports ensuring individual health and safety needs being are met. The coordinator is also responsible for conducting monitoring and follow-up to assess the quality of service implementation, and services are actually provided, and assuring that participants are satisfied with the services they are receiving.

Services are delivered under either the Self-Directed or Traditional Service Delivery Models provided ~~by~~ qualified by qualified providers (i.e. individuals, community-based service agencies, vendors, and entities) throughout the State. Services are provided based on each waiver participant's Person-Centered Plan to enhance the participant's and his/her family's quality of life as identified by the participant and his/her family through the person-centered planning process.

Services are provided by licensed community agencies and/or individuals and companies under the self-directed service delivery model. Providers offering licensed respite services must meet provider qualifications and have their provider owned and/or operated sites licensed. Services provided in the community or the person's own home such as personal supports, respite, and assistive technology and services must meeting provider qualifications to be certified by the DDA. Fiscal Management Services (FMS) and Support Brokerage services are also provided for individuals that use the self-directed service delivery option. This organizational structure provides a coordinated community-based service delivery system so that people receive appropriate services oriented toward the goal of full integration into their community.

### 3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. **Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. **Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. **Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

|                                  |   |
|----------------------------------|---|
| <input checked="" type="radio"/> | <b>Yes. This waiver provides participant direction opportunities.</b> <i>Appendix E is required.</i>            |
| <input type="radio"/>            | <b>No. This waiver does not provide participant direction opportunities.</b> <i>Appendix E is not required.</i> |

- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

|                                  |                       |
|----------------------------------|-----------------------|
| <input type="radio"/>            | <b>Not Applicable</b> |
| <input type="radio"/>            | <b>No</b>             |
| <input checked="" type="radio"/> | <b>Yes</b>            |

- C. Statewidelessness.** Indicate whether the State requests a waiver of the statewidelessness requirements in §1902(a)(1) of the Act (*select one*):

|                                  |            |
|----------------------------------|------------|
| <input checked="" type="radio"/> | <b>No</b>  |
| <input type="radio"/>            | <b>Yes</b> |

If yes, specify the waiver of statewidelessness that is requested (*check each that applies*):

|                          |  |
|--------------------------|--|
| <input type="checkbox"/> | <p><b>Geographic Limitation.</b> A waiver of statewidelessness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.</p> <p><i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p> |
|--------------------------|--|

|                          |   |
|--------------------------|---|
|                          |   |
| <input type="checkbox"/> | <p><b>Limited Implementation of Participant-Direction.</b> A waiver of statewideness is requested in order to make <i>participant direction of services</i> as specified in <b>Appendix E</b> available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.</p> <p><i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p> |
|                          |   |

## 5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
  1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
  1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services.

**Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

## 6. Additional Requirements

*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

The DDA partners with people in services, self-advocates, family members, service providers, advocacy organizations, and subject matter experts to enhance services and supports for Marylanders with developmental disabilities. This partnership includes working with various groups related to employment, self-direction, supporting families, person-centered planning, coordination of services, supporting children, training, system platforms, and rates, and more.

The DDA also shares information and overviews of the waiver and services for various groups. These events provide opportunities to obtain additional information, input, and recommendations from participants that can influence waiver services, policies, and procedure changes.

The DDA recognizes and appreciates the diversity of input we receive from stakeholders. We carefully considered input and recommendations from people with developmental disabilities and various stakeholders for changes to our services, processes, and policies. The amendment is a result of input and recommendations the DDA has received from stakeholders.

The following list Examples of groups, meetings, subject matter experts, and presentations include:



Monthly Statewide Behavior Supports Committee monthly meetings were held related to behavioral supports services to include seeking input related to staff qualifications, requirements, and training.

The DDA Transformation Advisory Committee held meetings to share information and obtain input related to transformation efforts including waiver services challenges and concerns on- June 12, 2018, September. 10, 2018, October 25th 2018, November 16, 2018 December 6, 2018, and January 11, 2019

The DDA Coalition Meetings were held on to share information and obtain input related to the service delivery system including waiver services— July 10, 2018, August 2, 2018, and December 19, 2018

The Maryland Association of Community Services (MACS) mMeetings was held on to share information and obtain input related to the service delivery system including waiver services— September 13, 2018

The Self-Directed Advocacy Network (SDAN) held quarterly meetings. to share information and obtain input related to the service delivery system including waiver services—Quarterly basis

The Applied Self-Directions (ASD) monthly calls with hosted subject matter experts to discuss various service delivery components related to self-directed services including training and curriculum development; waivers services and national best practices.

The Service Authorization Work Group held four meetings in July and one in August 2018 to obtain input related to waiver services authorization and billing criteria –July 18, 2018; July 19, 2018; July 24, 2018; July 25, 2018; and August 3, 2018

The Community Coordination Coalition (CCC) to shared information and obtain input related to the service delivery system including and waiver services input monthly.—3rd2nd Thursday of every month

The Technical Work Group to shared information and obtain input related to services and rates - on June 13, 2018.; August 10, 2018.; August 31, 2018.; and October 26, 2018.

Maryland's Long Term Services and Supports (LTSSMarylandLTSS) Provider Work Group to shared information and obtain input related to the service delivery system including waiver services monthly from— July 10, 2018; August 7, 2018; September 4, 2018; October 2, 2018; November 6, 2018; December 4, 2018; and to January 8, 2019

DDA Public Presentations – examples including:

1. The Hussman CenterInstitute – Self-Directed Service Delivery Model presentation on July 24, 2018
2. Maryland Association of Community Services (MACS) General Membership Meeting - DDA updates on September 13, 2018
3. Quality Trust – Understanding the DDA Waivers on October 20, 2018 and DDA Service Delivery Models on November 3, 2018
4. Transition Resource Fair - Navigating Toward Independence – Overview of the DDA Service Delivery Models on November 17, 2018
5. Maryland Association of Community Services (MACS) Conference - DDA Hot Topics including waiver amendments on November 30, 2018

6. Kennedy Krieger Institute – DDA Overview including waivers and services on December 7, 2018
7. Parents Place of Maryland – DDA Overview including waivers and services on January 25, 2019

#### DDA Transformation Newsletter and Email

On January 17, 2019, the DDA sent out information to all stakeholders and partners regarding the Waiver amendment application and upcoming overview webinars. In addition, information about the upcoming amendment has been shared in the DDA Transformation Newsletter including the September 18, 2018 and January 23, 2019.

#### Dedicated DDA Amendment Webpage

The DDA established a dedicated DDA Waivers - Amendment #1 2019 webpage and posted information about the draft waiver amendment application, and the public webinar presentation. The website is located at: [https://dda.health.maryland.gov/Pages/DDA\\_Waivers-Amendment1\\_2019.aspx](https://dda.health.maryland.gov/Pages/DDA_Waivers-Amendment1_2019.aspx).

#### Waiver Amendment Overview

The DDA will conducted two DDA Amendments Overview Webinars on February 2, 2019 from 1 p.m. to 2 p.m. and February 4, 2019 from 10 a.m. to 11 a.m. to share an overview of the proposed amendment. The same presentation will was be provided at both times. The DDA will also holdheld a meeting on February 11, 2019 from 6:30 to 8:30 p.m. to hear participants shared suggestions, recommendations, concerns, and provide an opportunity for questions.

#### Formal Public Comment Period

Stakeholders havehad the opportunity to provide additional input on the proposed amendment via the formal public input process that willwas be from February 2, 2019 through March 3, 2019.

The Maryland Urban Indian Organization (UIO) for Tribal Consultation was notified on February 1, 2019 (insert date) of the posting of the Waiver application.

From February 2, 2019 - March 3, 2019, stakeholders had the opportunity to provide input on the proposed amendment. Request for public input was also posted in the Maryland Register (Issue Date: February 1, 2019), which is available electronically or in hard copies as well as in different languages and formats to ensure accessibility statewide at the local health departments, DDA Headquarter Office and DDA Regional Offices.

The formal public comment period for Amendment #1 2019 proposal was held from February 2, 2019 - March 3, 2019. In total, 110 unduplicated individuals, families, providers, and advocacy agencies submitted input. Below is a summary of the comments received during the public comment period and the DDA's responses. A complete listing of all comments and responses can be found on the DDA website.

The DDA received a comment of appreciation and support of amendments intended to bring about consistency and clarity across the three waivers. Nine comments related to language changes in the Purpose of the HCBS Program section. Suggested language changes included: specifying input from innovative processes be required; requiring specific training for coordinators of

community services (CCSs), caregivers, and staff; providing emergency funding; and using the words “employees”, “employees and vendor staff” and “vendor staff” when appropriate were not accepted. The DDA explained the input process, current training requirements, the availability of emergency funding, and why “employee” was used. Accepted suggestions include clarifying CCSs’ monitoring roles and responsibilities and services intent for increasing independence.

Three comments were received for Appx. A. Providers’ suggestions to remove discharge language from nursing case management and delegation and comments regarding the age limit of respite providers were not accepted. The DDA explained that delegation may be needed after discharges, and lowering the required age limit of respite providers to 16; explaining that stakeholders requested the change.

Two comments were received for Appx. B regarding reserved capacity and CCS monitoring. Slot categories were explained and the DDA agreed to consider provider capacity for TYs and Foster Kids. A CCS quarterly monitoring adjustment suggestion was accepted.

Twelve comments were received for Appx. C. A suggestion to include the title and form number of the Supportive Decision Making Agreement was not accepted as it is an agreement and not a standard form. A comment that provider applications not be required for providers of self-directed services, or individuals/businesses licensed in Maryland was not accepted. The DDA explained that applications are needed for providers where only budget authority is offered. The DDA provided clarification to comments regarding DDA approved/DDA certified vs licensed providers, and that a formal certification process is needed. The DDA explained that a formal provider approval process is in place for DDA providers to be certified or licensed. A comment that the Maryland Board of Nursing requirement of certification for unlicensed direct support providers is a hardship was received; the DDA explained this is Maryland law. Three comments regarding criminal background checks limiting community access were not accepted; DDA explained that criminal background checks are needed to protect waiver participants. The DDA did not accept suggestions to add a grandfather clause for participants who will no longer meet new language; that criteria for payments are removed; that service definitions are restrictive and overlapping; and State Plan policy language goes against waiver’s purpose. The DDA explained that service definitions give participants choice and flexibility and that accessing State Plan policy language is required by Centers for Medicare and Medicaid Services (CMS).

The DDA received two comments for assistive technology and services. The DDA explained that DDA applications are not needed and that training requirements are required for assistive technology professionals who provide self-directed services.

Five comments were received regarding behavioral support services. One comment that behavior consultation service units be changed to 15 minutes were accepted. Two comments were affirmed, that only licensed professionals should oversee services. A comment stated that competency requirements are redundant and another recommended removing Functional Behavior Analysis and Antecedent Behavior Consequence language were not accepted. The DDA advised that competencies explain provider requirements for providing service and explained that Functional Behavior Analysis and Antecedent Behavior Consequence language would remain due to regulations.

Nine comments were received for individual and family directed goods and services. Comments suggested offering individual and family goods and services under the traditional service delivery model; to remove or increase the cap; to cover service animals and smartphones; and to cover classes and activities in the community were not accepted. The DDA will consider expanding the list of covered items in the future. Options are available through other Medicaid programs and



other waiver services for service animals, smartphones, and community activities (classes). Comment suggested that service be flexible to support access to qualified providers. The DDA explained that providers and services are broad for inclusion of commercial businesses, community organizations, and licensed professionals.

Two comments were received for participant education, training and advocacy supports. As transportation is included in participant education, training and advocacy supports; and standalone transportation service can be used, the suggestion to increase a cap was not accepted. The DDA explained that educational opportunities available outside of waiver services can also be explored, and did not accept a suggestion to increase the 10 hours/year limit.

The DDA received 22 comments for personal supports. One comment that personal supports is limiting and goes against person-centered planning. The DDA explained that personal supports is designed to complement waiver and other community services so participants receive needed supports. A suggestion to add language that emphasizes support was accepted. A suggestion to include travel time in the rate was received. The DDA explained the rate includes transportation but travel to and from the service cannot be billed. The DDA accepted a suggestion that service be offered anytime Meaningful Day supports are not in session. There was a comment of disagreement with overnight supports being removed from service. The DDA explained that personal supports is designed to be habilitative and differs from personal care offered in the State plan. A suggestion that assistive technology be used to support overnight coverage will not work. The DDA explained that medical need for support can be received through the State plan and concerns should be shared with the regional office director for further assistance. Advocates expressed concerns about weekday time restrictions; the DDA stated that personal supports is not limited to weekdays. The DDA did not accept suggestions to redefine service to include companion and homemaker supports or cover service gaps between DDA and State plan. The DDA did not accept suggestions to exclude self-directing participants from 82 hour limit or increase the limit, as more hours can be authorized if there is an assessed need. Recommendation to support those currently receiving over 82 hours of supports was submitted. The DDA explained hours are authorized based on need. The DDA accepted the suggestion to include maintenance of skills and health management in the definition. The DDA accepted the suggestion to include language around the cost-effectiveness and appropriateness of needs.

There were eight comments for respite. Advocates suggested allowing overnight supports in the home be covered under respite; the DDA confirmed it this is covered. The DDA accepted comments suggesting raising the funding cap and separate camp dollars from overnight respite hours. The respite limitation was increased to 720 hours in addition to camp. A comment suggested to include specialized respite and behavioral respite homes was not accepted; services are provided under administrative contracts. The DDA did not accept a comment to suggest offering behavioral supports during respite, as it is time limited and behavior support services is offered through other services. The DDA did not accept a comment suggesting removal of training requirements for contractors or family staff. DDA must comply with the Maryland Board of Nursing requirements.

Fourteen comments were received for support broker. One suggestion that language should encourage use of support brokers; the DDA explained it supports self-direction and support broker use, but it is optional. Suggestions to change language regarding support broker roles and responsibilities to include day to day management of the plan, developing and implementing strategies, signing timesheets, establishing budgets, assisting with budget and employer authority, or hiring/firing workers were not accepted. The DDA explained support broker is designed to support self-direction participants by giving employer related information and advice so the participant can make informed decisions about managing services. Advocates suggested adding

that support broker be the primary advocate for participants; the DDA did not accept, as the participant has the freedom to choose their primary advocate. Recommendation that support broker differs from case management in intensity, frequency and level of detail was not accepted. The DDA stated each service is different and this could apply to all services. The DDA did not accept a suggestion to remove language regarding participants' significant health and medical changes, as wording relates to additional supports being authorized above the limit. Advocates expressed concerns that 4 hour limit not being person-centered; the DDA explained the State is required to outline scope, nature, and limits of each service. The DDA accepted a suggestion to remove provider qualifications numbers 9 through 13.

Thirteen comments were received for transportation. Advocate comments suggested transportation be a standalone service for those in self-direction whether or not they are receiving support from another service at that time; the DDA did not accept, explaining the service is designed to support independent travel and transportation is part of Meaningful Day and residential services. Comments suggesting removal of the words "independently" and "agreement" from the definition were not accepted; when used, "independently" indicates the person accesses their community without staff supports, and "agreement" clarifies specific details related to mileage reimbursement. Comments regarding family members and individual legally responsible being paid for service were not accepted. The DDA explained "legally responsible individuals" is used by CMS, and relatives can be reimbursed. One comment that reimbursement criteria limits community access. The DDA explained service is designed for independent travel in community. Providers recommendation to restore vehicle purchases to service was not accepted, as this service is designed for independent travel; transportation is a part of meaningful day and residential services. A comment that individuals providing service under self-direction do not need a DDA application, the DDA confirmed this is the case.

Four comments were received for Appx. D. The DDA accepted a suggestion to revise language regarding CCSs ensuring health and safety or service delivery to reflect their monitoring role. Recommendation to clarify how a person-centered plan (PCP) is developed including assessment information; the DDA clarified that the CCS is responsible for gathering information about requested services with participant/representative input, remaining members of the team may also provide information. One comment received asked DDA to describe "back-up" plan in detail was not accepted; the DDA explained information related to back-up plans is found in Appx. D-1e.

Forty-two comments were received for Appx. E. Comments included the separation of home and community-based services are impractical and not wanted; self-direction service options were reduced; and self-direction is being discouraged due to the term "traditional services." The DDA explained that service changes are based on stakeholder input; offer new opportunities; and service options have increased including support brokers services. The DDA explained there are two service delivery models offered and that CCSs support participants regardless of service delivery model. Recommendation to use "participant" or "participant/designated representative" throughout document, concerns about self-direction criteria and suggestions to remove designated representative language were received. The DDA explained CMS uses "participant" related to individuals enrolled; designated representative is not required. The DDA deleted criteria and added wording that participant or their designated representative being capable of making decisions. Suggestion to restore the federal Independence Plus designation was not accepted; CMS stated to remove. A comment stating the financial management service (FMS) request for proposal (RFP) references the wrong start date was clarified by the DDA; the RFP is expected to be released summer of 2019. Comment that FMS should be a waiver service instead of administrative was not accepted, as FMS has traditionally been an administrative service. Concerns that more than one FMS is needed because one FMS may be a monopoly were considered. The DDA clarified it has a joint RFP request with MDH partners to acquire a high

quality FMS. Suggestions to revise FMS roles were not accepted as the DDA explained this service is designed to assist with employer and budget authority. Recommendation to change sentence about supports and protections were not accepted as the DDA explained it is a part of the amendment application template. A comment suggesting offering employer authority for employment discovery and customization, employment services, supported living, and to add shared living as a service with budget authority was not accepted as professional service standards and requirements have been established. The DDA accepted a suggestion to add the new self-direction manual's release date. The DDA did not accept a comment related to the Self-Direction Service Agreement as it is part of the template. The DDA accepted comments that self-direction budgets align with traditional budgets. Advocates suggested allowing participants to modify services within their plan without DDA approval; the DDA did not accept as to support payment of qualified providers a modification is needed in the PCP. This is not an available option in the amendment application. All modification to the budget must be preceded by a change in the service plan. Concerns about the support broker service being optional and comments regarding the support broker role and responsibilities were not accepted. The DDA explained support broker service is designed to provide specific information, coaching, mentoring, and assistance, as necessary and appropriate, if chosen by the participant. Comment suggesting that self-direction be an option for those in residential with less than 4 others was not accepted; as a self-direction option is available for those who live with others under a lease. Concerns that excessive requirements on licensed/certified professionals and benefit limitations for support staff will limit access to qualified providers. The DDA explained that requirements ensure health and safety. Comment concerned that staff benefits are limited was clarified by the DDA; benefits are allowed under certain services based on the participant's choice.

Two comments were received for Appx. F. A comment that new language lists five appeal topics that do not match up with the three topics mentioned in the introductory paragraph of Appendix F-1. The second comment sought clarification if appeal options were expanded, decreased or remained the same. The DDA clarified that language indicates how an individual and family are informed of their opportunity to request a Medicaid Fair Hearing and that appeal types remained the same.

The DDA accepted a comment for Appx. G to keep the word "approved" from standing committee role.

Sixteen comments were received for other matters. The DDA explained that services are designed to provide choice and flexibility in response to a comment that amendments are not flexible enough to address participants' needs. The DDA explained its goal is to support participants to live in the least restrictive environment with family ties, if that is their choice in response to a comment for programs to help participants stay with their families. Parents suggested participants and parents/guardians are able to review the Supports Intensity Scale assessment (SIS) before submission. The DDA explained parents/guardians should work closely with the participant and assessor so all are informed of what is being submitted. The DDA stated it expects all providers to properly train their staff as outlined in COMAR in response to a comment that staff do not last long due to lack of training. A suggestion to use "participant" instead of "individual" throughout the waiver was not accepted as the DDA uses "individual" to describe someone in the application processes and "participant" describes those in services. A comment suggesting covering activity costs for day habilitation, community development services, personal supports, and community living was not accepted, as Medicaid waiver funds do not cover activity costs. A provider suggested adding an acuity factor to rates. The DDA explained that an acuity factor is not used as rates are developed based on definition, staff qualifications, and level of need. A recommendation to consider a rate in brick for job development indirect and direct services; the DDA explained this will be explored in the future. Comments were made that overlapping services will lead to

billing errors and flexibility and rounding rules are needed. The DDA explained billing guidance will be provided based on a provider technical group's suggestions. A comment was made that including transportation in rate compromises ability to retain qualified staff and access services. The DDA did not accept comments related to travel reimbursement for community development services and personal supports under self-direction, as travel is a part of Meaningful Day and residential rates. Transportation is also a standalone service for independent travel. A comment regarding needed support for recruiting/hiring staff and exploring personal and community interests was addressed. The DDA explained funds for recruitment are available through Individual and Family Directed Goods and Services and that Charting the LifeCourse™ tools and services are designed to assist with interests. The DDA stated the reimbursement rate includes staff wages and employee related expenses such as benefits in response to a comment regarding low wages and lack of benefits for direct support staff.

The DDA hired independent consultants, which conducted listening sessions in 2014 on DDA's behalf. In these listening sessions families expressed interest in gaining access to nimble, responsive, and flexible supports for individuals with developmental disabilities under the age of 21 still living with their families.

The DDA developed this waiver application based on input from: (1) the Family Supports Waiver Steering Committee, which is composed of individuals on the DDA Waiting List and their families; (2) a survey and recommendations from the Developmental Disabilities Coalition ("DD Coalition"), which is composed of leaders from the Maryland's Developmental Disabilities Council, Maryland's Protection and Advocacy Agency, People on the Go of Maryland (a self-advocate led organization), Maryland Association of Community Services (the largest community-based service agencies provider association in Maryland), and the Arc of Maryland; (3) Self-Directed Advocacy Network; (4) independent consultants; (5) national research; (6) public regional input forums conducted June 16, 2017 through June 22, 2017; and (7) submitted public comments.

In partnership with the DD Coalition, the Developmental Disabilities Administration first sought national expertise from the National Association of State Directors of Developmental Disabilities Services (NASDDDS) in the development of the initial framework for the Family Supports Waiver. NASDDDS works with states to develop systems of support for families throughout the lifespan of their family member with intellectual and developmental disabilities.

The DDA established a Family Supports Waiver Steering Committee to provide input regarding services to be included in this waiver and on recommendations from other stakeholders (e.g. the Developmental Disabilities Coalition, consultants, and public forums). This committee is comprised of a diverse representation of parents or other family caregivers, ranging in age of parent or caregiver, age of children (including the individual on the Waiting List), culture, disability, regional residence, and relationship, such as grandparents and a foster father.

Per the DDA's request, the DD Coalition fielded a widely distributed public survey seeking input on: (1) the types of supports and services children (young, elementary, middle school, and high school) with developmental disabilities need in their homes; (2) the types of supports children with developmental disabilities need in their communities; (3) the types of supports and services children with developmental disabilities need after school, in the evening, or on the weekend; (4) other types of supports and services children with developmental disabilities need; (5) types of supports and services family members (parents, siblings, etc.) need; and (6) additional thoughts, suggestions, and challenges for the DDA's consideration.

~~The DDA contracted with an independent consultant to research 22 states administering community support and family support waiver programs and shared results with both the Family Supports Waiver Steering Committee and the DD Coalition.~~

~~The DDA established a dedicated Family Supports Waiver webpage and posted information about the program's goals, draft service proposals, public forum meetings, draft waiver application, and public presentations including at the ARCre of Maryland Annual Conference, the Family Supports Waiver Steering Committee meeting, and public forums' presentations. The website is located at: [https://dda.health.maryland.gov/Pages/DDA\\_FAMILY\\_SUPPORTS\\_Waiver.aspx](https://dda.health.maryland.gov/Pages/DDA_FAMILY_SUPPORTS_Waiver.aspx).~~

~~The DDA announced and conducted regional public forums June 19–22, 2017, where information about the process and draft service descriptions was shared. At these public forms, the DDA solicited input on ways to enhance service proposals and provider qualifications.~~

~~The Maryland Urban Indian Organization (UIO) for Tribal Consultation was notified on June 12, 2017 of the upcoming posting of the Waiver application.~~

~~The DDA sent out information to all stakeholders and partners regarding Waiver application posting and request for public comment on June 30, 2017.~~

~~Request for public input was also posted in the Maryland Register (Issue Date: 6/26/17), which is available electronically or in hard copies as well as in different languages and formats to ensure accessibility statewide at the local health departments, DDA Headquarter Office and DDA Regional Offices.~~

~~The Public Comment Period was held from July 1, 2017–July 31, 2017. In total, 29 individuals responded. The following is a general summary of comments received.~~

~~One comment to work with Medicaid to create a single enhanced personal care service for people with developmental disabilities where they can have one plan and one case manager.~~

~~Response: The DDA and OHS will continue to provide assistance with coordinating Medicaid services and cannot restrict access to these services in favor of another service. All individual have the right to access the various Medicaid State Plan services based on their assessed needs. No change was made.~~

~~Two comments to offer Behavioral Support; Community Supports and Navigation; and Family Caregiver Training and Empowerment Services under the self-directed service delivery model.~~

~~Response: Behavioral Support and Family Caregiver Training and Empowerment Services will be offered under the self-directed service delivery model. Community Support and Navigation was removed due to similarities with Targeted Case Management services.~~

~~One comment to clarify the target group of child and youth to prevent confusion with the Community Pathways Waiver.~~

~~Response: The Family Supports Waiver includes individuals up to the age of 21. Individuals age 18–21 are considered by some State programs and the general public as adults. Language was changed to reflect participants or applicants.~~

~~One comment that Supporting Families Community of Practice language noted in each service description loses it meaning.~~

~~Response: The language was removed from each service description and as it is incorporated into the waiver description purpose and goals.~~



~~One comment to eliminate Assistive Technology requirement to select the least expensive option.  
Response: Assistive Technology services and devices are provided based on a need identified in the assistive technology assessment and the Person-Centered Plan. Based on the professional assessment and assessed need, the recommended assistive technology devices/equipment should meet the participant's needs. No change was made.~~

~~Comments from three individuals and one agency that the waiver should not fragment services.  
Response: Service description, scope, and standards language was enhanced to better clarify purpose and provide participants the flexibility to receive multiple services throughout the day.~~

~~One comment that Assistive Technology provider experience of three years may be too high.  
Response: In developing this service, the DDA met with a workgroup of professionals in the Assistive Technology field. Provider requirements for this service were based on their recommendations. In order to ensure appropriate assessment of needs, it is important for professionals to have experience. No change was made.~~

~~Four individuals commented on Behavioral Support Services. One agency had several comments related to Behavioral Support Services including: (1) eliminating some training requirements; (2) creating a workgroup to review supports; (3) adding language that the service compliments goals; (4) eliminating limitations to services; (5) defining functional behavioral assessment; (6) expressing concerns with the lack of psychiatrist, behavioral support, and crisis services under Medicaid; and (7) suggesting clarification on use of psychiatrist. One family member commented that service should be available under the individual's primary provider agency. Two individuals commented the service to be self-directed.~~

~~Response: In creating the services, the DDA sought input from stakeholders including a workgroup. The DDA will continue to review behavioral support services and seek input from individuals, family members, national expert, and service providers. The DDA shared with the OHS concerns related to the lack of qualified psychiatrists in the community. Hot lines, mobile crisis teams, and behavioral respite will continue to be provided as administrative services. Language was added to reflect the service is based on the principles of person-centered thinking. Limitations were modified to reflect the behavioral assessment is limited to one per year unless otherwise approved by DDA. Behavioral Consultation and Brief Support Implementation Services service hours are based on assessed needs, supporting data, plan implementation, and authorization from the DDA. Functional Behavior Assessment will be defined in regulations. Provider agencies can apply to provide the service to individuals they support. The self-directed service delivery model was added.~~

~~One agency had comments related to the new family support services including (1) using a broader definition of training, mentoring, and empowerment services that may include all or some of the components defined instead of separate services; (2) reconsider the "other standards" provider requirements related to services to children under 18; and (3) further guidance is needed on providers of participant education, training, and advocacy supports.~~

~~Response: The three new family support services are based on communities of practice. The DDA will monitor the implementation of these services and make adjustments as needed. Community Support and Navigation was removed due to similarities with Targeted Case Management services. Additional guidance on providers will be provided in recruitment efforts and regulations.~~

~~One comment to allow environmental assessments prior to entering services for transitioning youth.~~

~~Response: Services prior to enrollment is only available for individuals transitioning from an institution.~~

~~One comment related to eliminating requirement for ADA compliance for environmental modifications.~~

~~Response: No changes were made.~~

~~Seven individuals comment to remove requirement to explore and exhaust other services and that DDA is the payer of last resort.~~

~~Response: Federal guidance require accessing services funded under other Medicaid authorities such as the Rehabilitation Act prior to accessing waiver funding for the same service. Medicaid is the payer of last resort therefore this language was removed.~~

~~One comment that language should be added to personal supports to clarify it is available anytime when school is not in session and to remove the limitation.~~

~~Response: Language was added to clarify service availability when school is not in session and the limitation was removed as the program has a set budget cap.~~

~~One comment related to the need to clarify whether family and friends providing services under respite care are required to be certified as medication technicians.~~

~~Response: Individuals paid to provide the services must meet Maryland Board of Nursing requirements.~~

~~One agency commented on personal supports and transportation service proposal under the new waiver in comparison to proposals under the comprehensive waiver.~~

~~Response: Services will be standardized across waiver as applicable.~~

~~One agency commented that vehicle modification should be permitted every five years.~~

~~Response: This service was aligned with the Division of Rehabilitation Services standard of once every ten years.~~

~~One agency commented the proposed administrative fee for the Agency with Choice FMS will not be sufficient to cover provider's cost.~~

~~Response: This model was removed. The DDA will continue to utilize the current self-directed service model of use of Support Brokers and Fiscal Management Services across all waivers.~~

~~One agency had several comments related to self-direction including: (1) removing specific rates or caps on rate to provide flexibility and prevent future amendments and public comment requirements; (2) add independent advocacy option; and (3) offer both Agency with Choice and Fiscal Employer Agent models.~~

~~Response: No changes were made to rates or caps. Several new family support services have advocacy and mentoring within them similar to the independent advocacy option. The DDA will continue to utilize the current self-directed service model of use of Support Brokers and Fiscal Management Services across all waivers.~~

~~One comment to add Autism in the target group.~~

~~Response: Similar to the Community Pathways Waiver, individuals with autism that meet the developmental disability eligibility criteria could be eligible for the Family Supports Waiver. Therefore, this box is not check as a diagnosis of autism in itself does not meet the regulatory established developmental disability criteria.~~

~~One comment to remove exclusion for hooking up general use appliances to waiver provided generator.~~

~~Response: The purchase of generators are to support individuals with medical and health devices that require electricity. It is not for general household appliances such as washer and dryers, security systems, etc.~~

~~One comment to remove service restriction under Family and Peer Mentoring Supports related to supporting participants in locating and access other programs.~~

~~Response: These functions are required and provided under Targeted Case Management services.~~

~~One comment that Community Support and Navigation duplicates targeted case management services.~~

~~Response: This service was removed.~~

~~One comment related to removing the \$2,000 cap for Individual and Family Directed Goods and Services.~~

~~Response: The limitation was increased to \$5,000.~~

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

|                    |   |             |  |                          |            |
|--------------------|---|-------------|--|--------------------------|------------|
| <b>Last Name:</b>  | Hutchinson  |             |  |                          |            |
| <b>First Name:</b> | Marlana   |             |  |                          |            |
| <b>Title:</b>      | Deputy Director, Nursing and Waiver Services  |             |  |                          |            |
| <b>Agency:</b>     | Maryland Department of Health – Office of Long Term Services and Supports Health Services |             |  |                          |            |
| <b>Address :</b>   | 201 West Preston Street, 1 <sup>st</sup> Floor  |             |  |                          |            |
| <b>Address 2:</b>  |   |             |  |                          |            |
| <b>City:</b>       | Baltimore   |             |  |                          |            |
| <b>State:</b>      | Maryland  |             |  |                          |            |
| <b>Zip:</b>        | 21201   |             |  |                          |            |
| <b>Phone:</b>      | (410) 767-4003  | <b>Ext:</b> |  | <input type="checkbox"/> | <b>TTY</b> |
| <b>Fax:</b>        | (410) 333-6547  |             |  |                          |            |
| <b>E-mail:</b>     | marlana.hutchinson@maryland.gov   |             |  |                          |            |



- B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

|                    |   |             |  |                          |            |
|--------------------|---|-------------|--|--------------------------|------------|
| <b>Last Name:</b>  | Workman   |             |  |                          |            |
| <b>First Name:</b> | Rhonda  |             |  |                          |            |
| <b>Title:</b>      | Director of Federal Programs  |             |  |                          |            |
| <b>Agency:</b>     | Maryland Department of Health – Developmental Disabilities Administration |             |  |                          |            |
| <b>Address:</b>    | 201 West Preston Street, 4 <sup>th</sup> Floor                            |             |  |                          |            |
| <b>Address 2:</b>  |   |             |  |                          |            |
| <b>City:</b>       | Baltimore   |             |  |                          |            |
| <b>State:</b>      | Maryland  |             |  |                          |            |
| <b>Zip :</b>       | 21201   |             |  |                          |            |
| <b>Phone:</b>      | (410) 767-8692  | <b>Ext:</b> |  | <input type="checkbox"/> | <b>TTY</b> |
| <b>Fax:</b>        | (410) 333-5850  |             |  |                          |            |
| <b>E-mail:</b>     | Rhonda.Workman@maryland.gov   |             |  |                          |            |

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:**

\_\_\_\_\_  
State Medicaid Director or Designee

**Submission  
Date:**

|  |
|--|
|  |
|--|

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

|                    |  |  |  |  |  |
|--------------------|--|--|--|--|--|
| <b>Last Name:</b>  |  |  |  |  |  |
| <b>First Name:</b> |  |  |  |  |  |
| <b>Title:</b>      |  |  |  |  |  |
| <b>Agency:</b>     |  |  |  |  |  |
| <b>Address:</b>    |  |  |  |  |  |
| <b>Address 2:</b>  |  |  |  |  |  |
| <b>City:</b>       |  |  |  |  |  |
| <b>State:</b>      |  |  |  |  |  |
| <b>Zip:</b>        |  |  |  |  |  |
| <b>Phone:</b>      |  |  |  |  |  |
| <b>Fax:</b>        |  |  |  |  |  |
| <b>E-mail:</b>     |  |  |  |  |  |

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ Replacing an approved waiver with this waiver.
- ☐ Combining waivers.
- ☐ Splitting one waiver into two waivers.
- ☐ Eliminating a service.
- ☐ Adding or decreasing an individual cost limit pertaining to eligibility.
- ☒ Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- ☒ Reducing the unduplicated count of participants (Factor C).
- ☒ Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- ☐ Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- ☒ Making any changes that could result in reduced services to participants.

**Attachment #1: Transition Plan**

Specify the transition plan for the waiver:

The Family Supports amendment include various program related adjustment including the alignment of services scope, requirements, limitations, qualifications, and effective date for the three home and community-based service waivers programs that support individuals with developmental disabilities which includes the Family Supports Waiver, Community Supports Waiver, and the Community Pathways Waiver. It supports service transitions with additional time for person-centered service exploration, planning, and service implementation. Coordinators of Community Services (CCS) will continue to share information with participants and families about new service opportunities and changes to existing services during their annual person-centered planning process and when new needs arise. It also adjusts some of the new or revised service implementation to provide additional time for rate setting and development of critical operational and billing functionality. Payment systems will transition to Maryland's Long Term Services and Supports (LTSSMarylandMDLTSS) system on July 1, 2020.

SERVICE ENHANCEMENTS AND TRANSITIONS – SUPPORT SERVICESBehavioral Support Services changes include:

Provider qualifications and staff requirements were enhanced. Current providers will have up to twelve months to meet the new requirements. Qualified clinicians who complete the behavioral assessment and consultation must have:

1. A minimum of one year of clinical experience under the supervision of a licensed Health Occupations professional with training and experience in functional analysis and tiered behavior support plans with the I/DD population;
2. A minimum of one-year clinical experience working with individuals with co-occurring mental health or neurocognitive disorders; and
3. Competencies in areas related to:
  - (a) Analysis of verbal behavior to improve socially significant behavior;

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- (b) Behavior reduction/elimination strategies that promote least restrictive approved alternatives, including positive reinforcement/schedules of reinforcement;
- (c) Data collection, tracking and reporting;
- (d) Demonstrated expertise with populations being served;
- (e) Ethical considerations related to behavioral services;
- (f) Functional analysis and functional assessment and development of functional alternative behaviors and generalization and maintenance of behavior change;
- (g) Measurement of behavior and interpretation of data, including ABC (antecedent-behavior-consequence) analysis including antecedent interventions;
- (h) Identifying desired outcomes;
- (i) Selecting intervention strategies to achieve desired outcomes;
- (j) Staff/caregiver training;
- (k) Support plan monitors and revisions; and
- (l) Self-management.

Family and Peer Mentoring Services was updated with service limits to align with the DDA home and community-based services waivers. Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date.

Family Caregiver Training and Empowerment Services was updated with service limits to align with the DDA home and community-based services waivers. Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date.

Nurse Consultation and Nurse Case Management and Delegation Services have been added to support self-direction and delegation services for Personal Supports. Services also includes the opportunity for a relative, legal guardian, or legally responsible person to provide the service if authorized by the DDA.

Participant Education, Training and Advocacy Supports was updated with service limits to align with the DDA home and community-based services waivers. Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date.

Personal Supports changes include:

1. Personal Support Services rate will remain the same until new rates are finalized through the rate study. New rates will be implemented on July 1, 2020.
2. Transportation cost associated with the provision of services will be covered within the new rate effective July 2020.

Respite Care Services changes include:

1. A daily rate will be used for licensed sites and hourly rate for in/out of home services.
2. The service limit has been increased to include a daily/hourly limit up to 360720 hours/year plus up to \$7,248 toward camps.
3. Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date. This will support additional time for person-centered service exploration, planning, and service implementation. Participants seeking habilitation supports as an alternative to the basic break from the daily routine can seek additional Meaningful Day and Personal Support services.

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4. Adjustment to staff qualifications include removing the GED or High School Diplomas requirement and adjusting the age requirements to 16 years.

Support Broker Services

1. Optional service for participant's choosing to self-direct services.
2. Service definition and requirements were updated to align with the DDA home and community-based services waivers and to clarify the coaching and mentoring scope.
3. Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date. This will support additional time for person-centered service exploration, planning, and service implementation. Participants will be assisted in exploring other options including community opportunities and Participant Education, Training and Advocacy Supports.

Transportation was updated with service limits to align with the DDA home and community-based services waivers. Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date.

SELF DIRECTION

Nurse Consultation and Nurse Case Management and Delegation Services have been added as self-directed services.

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

Not applicable

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**Additional Needed Information (Optional)**

Provide additional needed information for the waiver (optional):

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Proposal

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## Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

|                                  |  |  |
|----------------------------------|--|--|
| <input checked="" type="radio"/> | The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program ( <i>select one</i> ):  |  |
| <input type="radio"/>            | The Medical Assistance Unit ( <i>specify the unit name</i> ) ( <i>Do not complete Item A-2</i> )   |  |
| <input checked="" type="radio"/> | Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/unit name.<br>This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. ( <i>Complete item A-2-a</i> )  | <b>Developmental Disabilities Administration (DDA)</b> |
| <input type="radio"/>            | The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. Specify the division/unit name:   |  |
|                                  |  |  |
|                                  | In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. ( <i>Complete item A-2-b</i> ). |  |

2. **Oversight of Performance.**

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities.

The Maryland Department of Health (MDH) is the Single State Medicaid Agency (SMA) authorized to administer Maryland's Medical Assistance Program. MDH's **Office of Health Services (OHS)**/**Office of Long Term Services and Supports (OLTSS)** is the Medicaid unit within the SMA that oversees the Family Supports Waiver. In this capacity, **OHS/OLTSS** oversees the performance of the Developmental Disabilities Administration (DDA), Operating State Agency (OSA) for the waiver. The **OHS/OLTSS** serves as the point of contact with the Centers for Medicare and Medicaid Services (CMS) with programmatic expertise and support from DDA.

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The DDA is responsible for the day-to-day operations of administering this waiver, including but not limited to enrolling participants into the waiver, reviewing and approving community-based agencies and licensure applications for potential providers, monitoring claims, and assuring participants receive quality care and services based on the assurances requirements set forth in this waiver. The DDA is responsible for collecting, trending, prioritizing and determining the need for system improvements.

**OHSOLTSS** will meet regularly with DDA to discuss waiver performance and quality enhancement opportunities. Furthermore, the DDA will provide **OHSOLTSS** with regular reports on program performance. In addition, **OHSOLTSS** will review all waiver-related policies issued. **OHSOLTSS** will continually monitor DDA's performance and oversight of all delegated functions through a data-driven approach. If any issues are identified, **OHSOLTSS** will work collaboratively with DDA to remediate such issues and to develop successful and sustainable system improvements. **OHSOLTSS** and the DDA will develop solutions guided by waiver assurances and the needs of waiver participants. **OHSOLTSS** will provide guidance to DDA regarding recommended changes in policies, procedures, and systems.

A detailed Interagency Agreement (IA) outlines the roles and responsibilities related to waiver operation and those functions of the division within **OHSOLTSS** with operational and oversight responsibilities.

**b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Not applicable

- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

☒ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

As further described below, the DDA currently contracts with community organizations for assistance and services in the following areas: (1) Participant Waiver Applications; (2) Support Intensity Scale (SIS)®; (3) Quality Assurance; (4) System Training; (5) Research and Analysis; (6) Fiscal Management Services; (7) Health Risk Screening Tool; (8) MD-Long Term Services and Supports Information System; and (9) Behavioral and Mental Health Crisis Supports.

**1. Participant Waiver Application**

The DDA contracts with independent community organizations and local health departments ~~as~~ **Coordinators** of Community Services to perform intake activities, including taking applications to participate in the waiver and referrals to county, local, State, and federal programs and resources.

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**2. Support Intensity Scale (SIS)®**

The DDA contracts with an independent community organization to conduct the Support Intensity Scale SIS®. The SIS® is an assessment of a participant's needs to support independence. It focuses on the participant's current level of support needs instead of focusing on skills or abilities they may not currently demonstrate. The Coordinators of Community Service use each completed SIS® as a planning guide in the development of the participant's Person-Centered Plan.

**3. Quality Assurance**

The DDA contracts with independent community organizations to conduct and analyze results from the National Core Indicator (NCI) surveys. The DDA will be contracting for a Quality Improvement Organization-like organization to support administrative functions related to technical assistance, quality assurance, and utilization review.

**4. System Training**

The DDA contracts with independent community organizations to provide trainings for individuals, their family members, community providers, Coordinators of Community Services, Support Brokers, DDA staff, and others related to various topics to support service delivery (i.e. person-centered planning), health and welfare (i.e. choking prevention), and workforce development (i.e. alternative communication methods).

**5. Research and Analysis**

The DDA contracts with independent community organizations and higher education entities for research and analysis of waiver service data, trends, options to support waiver assurances, financial strategies, and rates.

**6. Fiscal Management Services**

The DDA contracts with independent community organization for fiscal management services to support participants that are enrolled in the DDA's Self-Directed Services ~~Program~~ Model, as described in Appendix E.

**7. Health Risk Screen Tool**

The DDA contracts with Health Risk Screening, Inc. for training and the use of an electronic Health Risk Screen Tool (HRST) to identify health and safety risk factors for participants and to assist with determining health related support needs and training.

**8. ~~LTSS~~ Maryland - Long Term Services and Supports Information System**

The MDH contracts with information technology organizations for design, revisions, and support of the database that supports waiver operations.

**9. Behavioral and Mental Health Crisis Supports**

The DDA contracts with independent community organizations for crisis hotline services, mobile crisis services, and behavioral respite services to support participants and families during behavioral and mental health crisis.

**10. Organized Health Care Delivery System providers**

Participants can select to use an Organized Health Care Delivery System (OHCDS) provider to purchase goods and services from community agencies and entities that are not Medicaid providers. The OHCDS provider's administrative fee for the action is not charged to the participant.

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|                       |   |
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| <input type="radio"/> | <b>No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).</b> |
|-----------------------|---|

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select one*):

|                                  |   |
|----------------------------------|---|
| <input checked="" type="radio"/> | <b>Not applicable</b>   |
| <input type="radio"/>            | <b>Applicable</b> - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:   |
| <input type="checkbox"/>         | <b>Local/Regional non-state public agencies</b> conduct waiver operational and administrative functions at the local or regional level. There is an <b>interagency agreement or memorandum of understanding</b> between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i>            |
|                                  |   |
| <input type="checkbox"/>         | <b>Local/Regional non-governmental non-state entities</b> conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The <b>contract(s)</b> under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i> |
|                                  |   |

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The DDA is responsible for monitoring all contracts pertaining to administration and operations supporting this waiver.

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The DDA has a dedicated procurement function providing oversight of all legal agreements, including contracts and memoranda of understanding, into which the DDA enters.

Standard practice includes assignment of a contract monitor to provide technical oversight for each agreement, including specific administration and operational functions supporting the waiver as

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required in the agreement. Performance and deliverable requirements are set forth in each agreement, delineating service expectations and outcomes, roles, responsibilities, and monitoring.

DDA staff monitor each agreement and assess contract performance on an ongoing basis, depending on the specific contract requirements, but no less frequently than annually.

1. Participant Waiver Application – DDA reviews all applications daily for completeness as per DDA policy and provide technical assistance, training, or request corrective action as needed.
2. Support Intensity Scale (SIS)® - DDA's contract monitor reviews submitted invoices and documentation monthly related to completed Support Intensity Scale SIS®. Corrective actions are taken for discrepancies.
3. Quality Assurance – DDA's contract monitor reviews submitted data with the National Core Indicator (NCI) Reports upon receipt and initiates corrective actions as needed.
4. System Training – DDA staff review supporting documentation including attendance sheets upon receipt prior to approval of invoices.
5. Research and Analysis – DDA staff review activity reports and supporting documentation upon receipt prior to ~~service delivery~~ approval of invoices.
6. Fiscal Management Services – DDA staff conducts audits of FMS records for compliance with operational tasks annually and provide technical assistance, training, or request corrective action as needed.
7. Health Risk Screen Tool – DDA's contract monitor reviews submitted invoices and documentation related to completed HRSTs upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.
8. **LTSS**-Maryland - Long Term Services and Supports Information System – DDA staff review and authorize service deliverables based on work orders upon receipt.
9. Behavioral and Mental Health Crisis Supports - DDA's contract monitor reviews submitted invoices and documentation related to delivered services as per the contract upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.
10. Crisis hotline services, mobile crisis services, and behavioral respites services - DDA's contract monitor reviews submitted invoices and documentation related to delivered services as per the contract upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.
11. Organized Health Care Delivery System providers - DDA audits service providers annually for compliance with DDA policy and regulation and provide technical assistance, training, or request corrective action as needed.

Assessment results will be shared with **OHSOLTSS** during monthly meetings.

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

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In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

| Function   | Medicaid Agency                     | Other State Operating Agency        | Contracted Entity                   | Local Non-State Entity   |
|--|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|
| Participant waiver enrollment  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |
| Waiver enrollment managed against approved limits                                    | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |
| Waiver expenditures managed against approved levels                                  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Level of care evaluation   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Review of Participant service plans  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Prior authorization of waiver services   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |
| Utilization management   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |
| Qualified provider enrollment  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |
| Execution of Medicaid provider agreements  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |
| Establishment of a statewide rate methodology  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Rules, policies, procedures and information development governing the waiver program | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Quality assurance and quality improvement activities                                 | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

#### a. Methods for Discovery: Administrative Authority

*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities..*

#### i Performance Measures

|                |  |
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*For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:*

- *Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver*
- *Equitable distribution of waiver openings in all geographic areas covered by the waiver*
- *Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014).*

*Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

|  |   |  |   |
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| <b>Performance Measure:</b>  | AA - PM1: Number and percent of annual Quality Reports submitted by DDA, to the <b>OHSOLTSS</b> , in the correct format and timely. N = # of Quality Reports submitted by DDA in the correct format and timely. D = # of Quality Reports <del>received</del> <b>required</b> by the <b>OHSOLTSS</b> . |  |   |
| <b>Data Source</b> (Select one) (Several options are listed in the on-line application): Other |   |  |   |
| If 'Other' is selected, specify: DDA Quality Report  |   |  |   |
|  | <b>Responsible Party for data collection/generation</b><br>(check each that applies)  | <b>Frequency of data collection/generation:</b><br>(check each that applies) | <b>Sampling Approach</b><br>(check each that applies)                 |
|  | <input checked="" type="checkbox"/> State Medicaid Agency   | <input type="checkbox"/> Weekly  | <input checked="" type="checkbox"/> 100% Review                       |
|  | <input type="checkbox"/> Operating Agency   | <input type="checkbox"/> Monthly   | <input type="checkbox"/> Less than 100% Review                        |
|  | <input type="checkbox"/> Sub-State Entity   | <input type="checkbox"/> Quarterly   | <input type="checkbox"/> Representative Sample; Confidence Interval = |
|  | <input type="checkbox"/> Other Specify:   | <input checked="" type="checkbox"/> Annually                                 |   |
|  |   | <input type="checkbox"/> Continuously and Ongoing                            | <input type="checkbox"/> Stratified: Describe Group:                  |
|  |   | <input type="checkbox"/> Other Specify:                                      |   |
|  |   |  | <input type="checkbox"/> Other Specify:                               |

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| <b>Performance Measure:</b> | AA - PM2: Number and percent of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. N = # of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. D = # of providers |
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| <b>Data Source</b> (Select one) (Several options are listed in the on-line application): Reports to State Medicaid Agency on delegated Administrative functions |  |  |   |
| If 'Other' is selected, specify:  |  |  |   |
|   | <b>Responsible Party for data collection/generation</b><br>(check each that applies) | <b>Frequency of data collection/generation:</b><br>(check each that applies) | <b>Sampling Approach</b><br>(check each that applies)                 |
|   | <input checked="" type="checkbox"/> State Medicaid Agency                            | <input type="checkbox"/> Weekly  | <input checked="" type="checkbox"/> 100% Review                       |
|   | <input type="checkbox"/> Operating Agency  | <input type="checkbox"/> Monthly   | <input type="checkbox"/> Less than 100% Review                        |
|   | <input type="checkbox"/> Sub-State Entity  | <input checked="" type="checkbox"/> Quarterly                                | <input type="checkbox"/> Representative Sample; Confidence Interval = |
|   | <input type="checkbox"/> Other Specify:  | <input type="checkbox"/> Annually  |   |
|   |  | <input type="checkbox"/> Continuously and Ongoing                            | <input type="checkbox"/> Stratified: Describe Group:                  |
|   |  | <input type="checkbox"/> Other Specify:                                      |   |
|   |  |  | <input type="checkbox"/> Other Specify:                               |

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| <b>Performance Measure:</b> | AA - PM3: Number and percent of waiver policies approved by the <b>OHSOLTSS</b> .<br>N = Number of waiver policies approved by the <b>OHSOLTSS</b> D = Total number of waiver policies issued. |
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| <b>Data Source</b> (Select one) (Several options are listed in the on-line application): Presentation of policies or procedures |  |  |   |
| If 'Other' is selected, specify:  |  |  |   |
|   | <b>Responsible Party for data collection/generation</b><br>(check each that applies) | <b>Frequency of data collection/generation:</b><br>(check each that applies) | <b>Sampling Approach</b><br>(check each that applies)                 |
|   | <input checked="" type="checkbox"/> State Medicaid Agency                            | <input type="checkbox"/> Weekly  | <input checked="" type="checkbox"/> 100% Review                       |
|   | <input type="checkbox"/> Operating Agency  | <input type="checkbox"/> Monthly   | <input type="checkbox"/> Less than 100% Review                        |
|   | <input type="checkbox"/> Sub-State Entity  | <input type="checkbox"/> Quarterly   | <input type="checkbox"/> Representative Sample; Confidence Interval = |
|   | <input type="checkbox"/> Other Specify:  | <input checked="" type="checkbox"/> Annually                                 |   |
|   |  | <input checked="" type="checkbox"/> Continuously and Ongoing                 | <input type="checkbox"/> Stratified: Describe Group:                  |
|   |  | <input type="checkbox"/> Other Specify:                                      |   |
|   |  |  | <input type="checkbox"/> Other Specify:                               |

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| <b>Performance Measure:</b>  | AA - PM4: Number and percent of quarterly meetings held over a fiscal year to specifically monitor progress of performance measures. N = # of quarterly meetings held during the fiscal year that focused on monitoring of performance measures. D = # of quarterly meetings scheduled during the fiscal year. |  |   |
| <b>Data Source (Select one)</b> (Several options are listed in the on-line application): Meeting Minutes |  |  |   |
| If 'Other' is selected, specify:   |  |  |   |
|  | <b>Responsible Party for data collection/generation</b><br>(check each that applies)   | <b>Frequency of data collection/generation:</b><br>(check each that applies) | <b>Sampling Approach</b><br>(check each that applies)                 |
|  | <input checked="" type="checkbox"/> State Medicaid Agency  | <input type="checkbox"/> Weekly  | <input checked="" type="checkbox"/> 100% Review                       |
|  | <input type="checkbox"/> Operating Agency  | <input type="checkbox"/> Monthly   | <input type="checkbox"/> Less than 100% Review                        |
|  | <input type="checkbox"/> Sub-State Entity  | <input checked="" type="checkbox"/> Quarterly                                | <input type="checkbox"/> Representative Sample; Confidence Interval = |
|  | <input type="checkbox"/> Other Specify:  | <input type="checkbox"/> Annually  |   |
|  |  | <input type="checkbox"/> Continuously and Ongoing                            | <input type="checkbox"/> Stratified: Describe Group:                  |
|  |  | <input type="checkbox"/> Other Specify:                                      |   |
|  |  |  | <input type="checkbox"/> Other Specify:                               |

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| <b>Performance Measure:</b>  | AA - PM5: Number and percent of Type 1 - <u>Priority A</u> incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the <u>OHSOLTSS</u> . N = # of Type 1 - <u>Priority A</u> incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the <u>OHSOLTSS</u> . D = Number of Type 1 - <u>Priority A</u> incidents of abuse, neglect or exploitation reviewed by the <u>OHSOLTSS</u> . |  |   |
| <b>Data Source (Select one)</b> (Several options are listed in the on-line application): Other |   |  |   |
| If 'Other' is selected, specify: PCIS2 PORII Module  |   |  |   |
|  | <b>Responsible Party for data collection/generation</b><br>(check each that applies)  | <b>Frequency of data collection/generation:</b><br>(check each that applies) | <b>Sampling Approach</b><br>(check each that applies)                 |
|  | <input checked="" type="checkbox"/> State Medicaid Agency   | <input type="checkbox"/> Weekly  | <input checked="" type="checkbox"/> 100% Review                       |
|  | <input type="checkbox"/> Operating Agency   | <input type="checkbox"/> Monthly   | <input type="checkbox"/> Less than 100% Review                        |
|  | <input type="checkbox"/> Sub-State Entity   | <input checked="" type="checkbox"/> Quarterly                                | <input type="checkbox"/> Representative Sample; Confidence Interval = |
|  | <input checked="" type="checkbox"/> Other Specify: Office of Health Care Quality  | <input type="checkbox"/> Annually  |   |
|  |   | <input type="checkbox"/> Continuously and Ongoing                            | <input type="checkbox"/> Stratified: Describe Group:                  |
|  |   | <input type="checkbox"/> Other Specify:                                      |   |

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|  |  |  | <input type="checkbox"/> Other Specify:                               |
| <b>Performance Measure:</b>  | AA - PM6: Number and percent of on-site death investigations conducted by the OHCQ that met requirements. N = # of on-site death investigations reviewed by the OHCQ that met requirements. D = # of on-site death investigations reviewed by the OHCQ |  |   |
| <b>Data Source</b> (Select one) (Several options are listed in the on-line application): Record <del>reviews</del> <u>Review</u> , on site |  |  |   |
| If 'Other' is selected, specify:   |  |  |   |
|  | <b>Responsible Party for data collection/generation</b><br>(check each that applies)   | <b>Frequency of data collection/generation:</b><br>(check each that applies) | <b>Sampling Approach</b><br>(check each that applies)                 |
|  | <input checked="" type="checkbox"/> State Medicaid Agency  | <input type="checkbox"/> Weekly  | <input checked="" type="checkbox"/> 100% Review                       |
|  | <input type="checkbox"/> Operating Agency  | <input type="checkbox"/> Monthly   | <input type="checkbox"/> Less than 100% Review                        |
|  | <input type="checkbox"/> Sub-State Entity  | <input checked="" type="checkbox"/> Quarterly                                | <input type="checkbox"/> Representative Sample; Confidence Interval = |
|  | <input type="checkbox"/> Other Specify:  | <input type="checkbox"/> Annually  |   |
|  |  | <input type="checkbox"/> Continuously and Ongoing                            | <input type="checkbox"/> Stratified: Describe Group:                  |
|  |  | <input type="checkbox"/> Other Specify:                                      |   |
|  |  |  | <input type="checkbox"/> Other Specify:                               |

- ii If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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**b. Methods for Remediation/Fixing Individual Problems**

- i Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Office of Health Services (OHS) Office of Long Term Services and Supports (OLTSS) within the State Medicaid Agency (SMA) is responsible for ensuring that the DDA performs its assigned waiver operational and administrative functions in accordance with the waiver requirements. To this end, OHSOLTSS has developed communication and reporting mechanisms to track performance measures as detailed herein.

The DDA submits an Annual Quality Report to OHSOLTSS. It is a report on the status of waiver performance measures and includes discovery findings, remediation strategies, challenges, and system improvements associated with each waiver assurance including Level of Care, Service Plan, Qualified Providers, Health and Welfare, Financial Accountability, and Administration. The report includes any barriers to data collection and remediation steps. The OHSOLTSS, upon review of the report, will meet

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with DDA to address problems and barriers. Guidance from **OHSOLTSS** to DDA regarding changes in policies, procedures, or other system changes will be dependent upon the problems or barriers identified. **OHSOLTSS** and DDA communicate regularly and meet quarterly to discuss performance measures. If problems are identified regarding delegated functions, **OHSOLTSS** and DDA develop solutions guided by waiver assurances and the needs of waiver participants with **OHSOLTSS** exercising ultimate authority to approve such solutions.

**ii Remediation Data Aggregation**

| <b>Remediation-related Data Aggregation and Analysis (including trend identification)</b> | <b>Responsible Party (check each that applies)</b>        | <b>Frequency of data aggregation and analysis: (check each that applies)</b> |
|---|---|--|
|   | <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly  |
|   | <input type="checkbox"/> Operating Agency                 | <input type="checkbox"/> Monthly   |
|   | <input type="checkbox"/> Sub-State Entity                 | <input checked="" type="checkbox"/> Quarterly                                |
|   | <input type="checkbox"/> Other<br>Specify:                | <input type="checkbox"/> Annually  |
|   |   | <input type="checkbox"/> Continuously and Ongoing                            |
|   |   | <input type="checkbox"/> Other<br>Specify:                                   |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

|                                  |     |
|----------------------------------|-----|
| <input checked="" type="radio"/> | No  |
| <input type="radio"/>            | Yes |

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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